

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**
FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

0 1 — 0 1 7

2. STATE:

IOWA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL
SECURITY ACT (MEDICAID)TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

APRIL 1, 2001

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 431.11

7. FEDERAL BUDGET IMPACT:

a. FFY 01 \$ 0
b. FFY 02 \$ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 1.2-B, page 2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):

Attachment 1.2-B, pages 2-5 (MS-99-14)

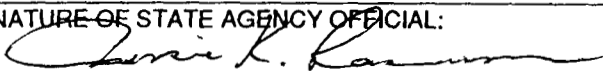
10. SUBJECT OF AMENDMENT:

Updated table of organization for the Division of Medical Services

11. GOVERNOR'S REVIEW (Check One):

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT☐ OTHER, AS SPECIFIED:☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL:



13. TYPED NAME:

Jessie K. Rasmussen

14. TITLE:

Director

15. DATE SUBMITTED:

July 10, 2001

7-10-01

16. RETURN TO:

Director
Department of Human Services
Hoover State Office Building
Des Moines, IA 50319-0114

17. DATE RECEIVED:

07/16/01

18. DATE APPROVED:

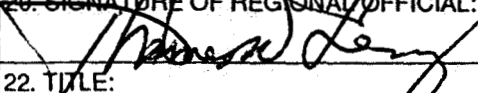
JUL 23 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

APR 01 2001

20. SIGNATURE OF REGIONAL OFFICIAL:



21. TYPED NAME:

Thomas W. Lenz

22. TITLE:

ARA for Division of Medicaid & State Operatio

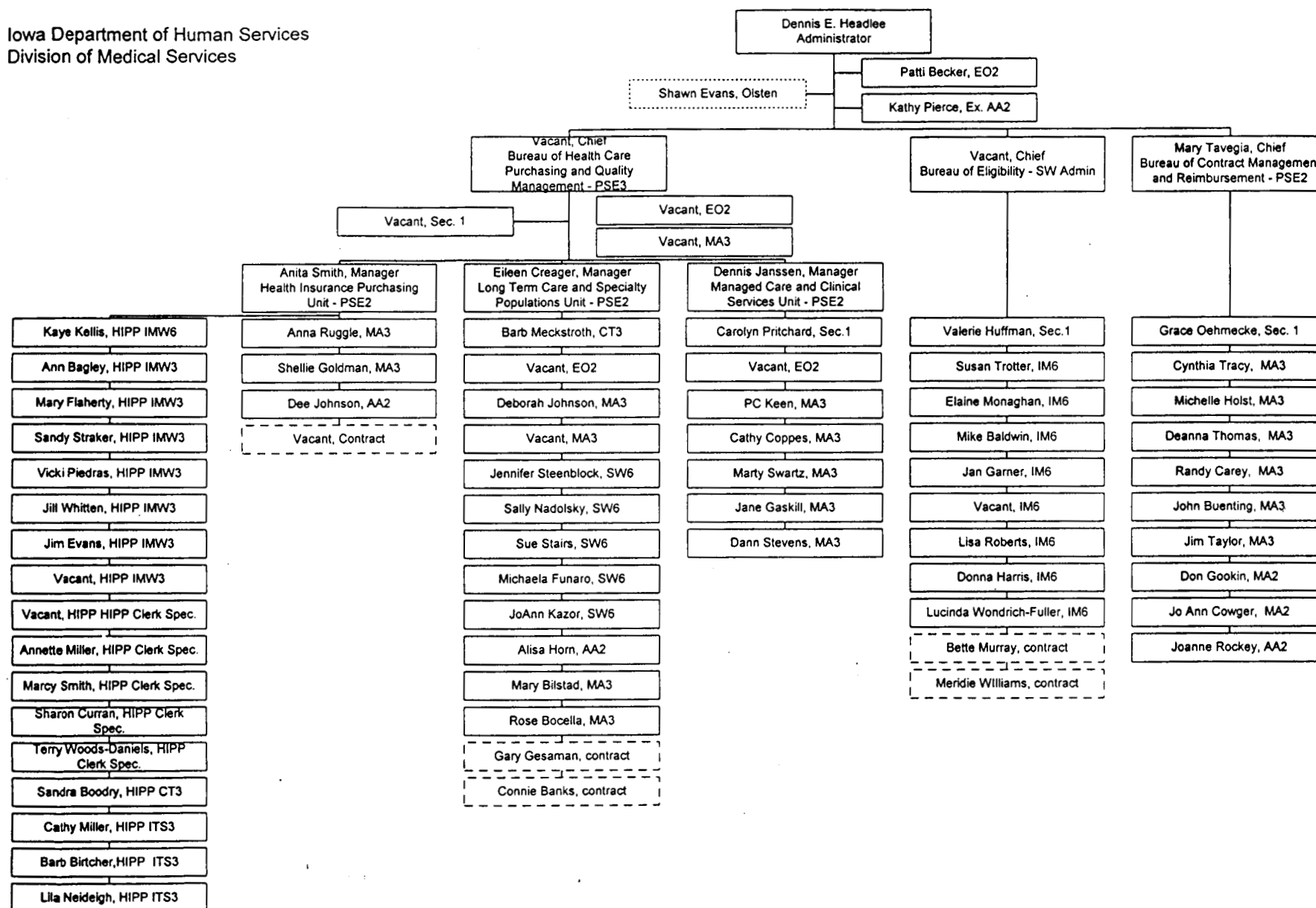
23. REMARKS:

SC: Rasmussen
Headlee

SPA CONTROL
Date Submitted: 07/11/01
Date Received: 07/16/01



Iowa Department of Human Services
Division of Medical Services



TN No. MS-01-17

Supersedes TN No. MS-99-14

Approved JUL 23 2001

Effective APR 01 2001